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ABSTRACT

Although the trauma that children experience in abusive situations differs from the trauma of a disaster, its effects are just as profound. The information and skills that caseworkers need to assess families and children who have been traumatized, to make more appropriate treatment planning decisions, and to carry out their professional roles with greater awareness of and sensitivity to the effects of trauma on children are presented in this manual. It is designed to accompany a one-day collaborative training session for caseworkers and foster care parents. During the post-traumatic stress period, safety and reassurance must be provided to the victims. This period can then lead to a process promoting remembrance and mourning, followed by the experience of reconnection and integration. Topics covered include: (1) Defining trauma; (2) Identifying trauma and the effects of psychic trauma; (3) The general effects of trauma on children; and (4) Building a case plan and understanding the treatment of trauma. The training plan includes specific learning objectives and uses exercises, video, and role play to prepare caseworkers and foster parents to help children to recover from trauma and create a fu[illegible]re. Resource lists include materials cited and a list of children's stories. An evaluation form is included. (EMK)

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Education and Research Institute for
FOSTERING FAMILIES

A Specialized Training Program
Designed to Enhance the Competency of
Caseworkers, Adoptive & Foster Parents

UNDERSTANDING AND ADDRESSING THE TRAUMA FROM ABUSE:

A MODEL OF SAFETY, RECONNECTION, AND INTEGRATION FOR VICTIMS OF ABUSE

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ABOUT THE AUTHORS

Mona Struhsaker Schatz, D.S.W., Associate Professor in the Social Work Department, Colorado State University and also serving as Principal Investigator and Director of the Education and Research Institute for Fostering Families, a comprehensive family and child welfare training development project. Involved in social work and child welfare education; primary areas of expertise include (1) social work theoretical development in generalist perspective at initial and advanced levels, (2) social work education and field education in social work, (3) children's services and child welfare practice, child development and attachment disorder, and (4) policy and practice issues in child welfare and families. Areas of social work practice since 1972 include children and family services, home health care, and private practice. Since the early seventies, Dr. Schatz has worked in child welfare and children's services in Colorado and several other states. In the 1970's, she served as a foster parent. In the 1980's she served on Greene County Missouri's Permanency Planning Committee. She has served as a member of the Colorado Child Welfare Advisory Committee. Dr. Schatz also provides training to professionals in Eastern Europe and Russia in family and child practice. She has published articles in Child Welfare and the Journal of Social Work Education, monographs, and several dozen original training manuals addressing the knowledge and skills to foster effective social work/human services practice and parenting.

Georgia A. Rigg, L.C.S.W., Associate Professor in the Social Work Department, Colorado State University, also maintains a private practice, since 1976, in Ft. Collins, and served as the co-founder and former Director of Adoptions: Advocacy and Alternatives. Ms. Rigg has trained extensively in psychodrama and other action therapies, primarily under the supervision of the late Leon D. Fine, Ph.D. She is completing her requirements for certification in psychodrama with John R. Mosher, M.A., T.E.P. of Seattle, WA. Ms. Rigg began her social work career as a child welfare caseworker in public social services. During her long tenure at Colorado Sate, she has taught courses in human behavior, generalist practice courses dealing with individuals, families, and groups, and clinical social work practice with individuals, families and groups. She has been involved in several training programs in Colorado and Wyoming. She has presented workshops in Colorado, Wyoming, and Montana dealing with a variety of approaches to team building, group therapy, family therapy, child welfare issues and treatment of victims of trauma. She specializes in the treatment of adult survivors of childhood physical, sexual, and emotional abuse.

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Education and Research Institute for

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The Education and Research Institute for Fostering Families, located in the Department of Social Work at Colorado State University, is an education, training, and research center seeking to improve social work and human service practice with families, youth and children, particularly families and children at risk and challenged. Fostering Families's Institute works through the Colorado Human Services Training, Education and Research Consortium. This collaboration includes Colorado's Department of Human Services, other social work programs, and various training centers in Colorado.

This Institute serves as an umbrella organization for four programs: (1) a stipend pre-employment program for social work students, (2) a "core" worker training program in family casework practice, (3) a foster parent core training program, and (4) an extensive series of on-going in-service training programs. Begun in 1986, Fostering Families is deeply committed to serving families, children and youth. It does so through the development of highly successful, experiential training programs that offer the most current knowledge for the field and offering an opportunity to test out different practice skills and intervention strategies available for the varied jobs in this arena.

FOSTERING FAMILIES is a unique opportunity for caseworkers and foster care parents, to explore the many complex aspects of child welfare including child abuse and neglect, family support and preservation, permanency planning, adoption and foster care delivery.

FOSTERING FAMILIES is specially designed to meet the varying learning and educational needs of training participants. Each training session uses different teaching and learning approaches such as groups, role play, sculpting, discussion groups, and individual learning exercises.

FOSTERING FAMILIES is designed to foster "a partnership of skill" among the many professionals responsible for the quality care of families and children in distress. Each training program seeks to provide an increased level of competence that can be shared by the varied professionals who may be working with a family or child.

FOSTERING FAMILIES is offered, in specific levels, as continuing education credit and upper-division college class work in the Social Work Department done in concert with the Division of Continuing Education at Colorado State University.

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INSTRUCTIONS FOR TRAINERS

Since 1986, Fostering Families has successfully designed and delivered training programs to thousands of workers and substitute care providers in child welfare. We have created a set of principles which infuse our training programs and serve as a philosophic base. Depending on the training program, some of these principles are addressed directly while others are reinforced. It is important to summarize the principles as a background to these instructions for the trainer.

Principle 1: First, our work with families and children who are served by public social services and the child welfare system, is extremely difficult and almost always stressful. These families frequently live in what is often termed "the culture of social and familial violence." These families and children live in an almost constant state of uncertainty-- experiencing great social and personal vulnerability, with few concrete resources to help them. By the time we see these at-risk families, they have experienced a great deal of tragedy, victimization, loss, social rejection, and defeat.

Principle 2: We recognize how difficult it is to deliver social work services in large, public bureaucracies, no matter how "nice" the individuals are. Bureaucracies are inherently cumbersome and often disregard the very people they should be serving, both their workers and their clients. Fostering Families believes we must be very attentive to these inherent flaws of bureaucracies and work intentionally toward minimizing these counter-productive effects. Training mirrors our environment(s); therefore, our training creates an environment and experiences that are validating and supportive of each participant. In training, we must repeatedly encourage efforts that build and sustain open communication and active problem-solving among all people. Attitudes such as blaming, and poor-me serve as self-fulfilling prophecies, and the resultant feeling of helplessness is draining and unproductive. Offering skills that improve communication, advocacy, networking, mediation, role clarification, team building, and professional relationships --helps build and foster effective practice.

Principle 3: A well of compassion and empathy must be built (brick by brick!) through the combination of daily practice, supervision, and training. We can not stay in this difficult work if we become strangled by our anger and disrespectful to the people with whom we work. We are not in our positions and roles to punish families and children. The atrocities and horrors that meet families and children in poverty and

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social violence can not be excused. Yet, caseworkers and substitute family environments, such as foster homes, are asked to look forward. Our job involves performing extensive assessments to identify where things are at the moment. Our job also requires us to repair what we can and fix what can be fixed. We must "make futures" for relinquished children and youth, etc. Our training must build our understanding, and most importantly, our skills to work effectively with these difficult families and children.

Purpose of the Manual

This training is built upon these principles. This training manual is a necessary tool for the trainer. In this section, we will describe how trainers can get the most out of this manual.

Serving equally as the trainee's manual, this booklet is a rich, valuable resource for their future use and reference. Concepts, principles, knowledge, and skills central to the training are written in the manual. A great deal of supporting documentation is also provided. At times, we know a training program can neither give equal attention to all the concepts related to the topic, nor introduce each small detail tied to the area under consideration. Group training experiences rarely focus on mastery of minute details. The manual, however, gives added documentation--access to more in-depth information to the trainee for later reference. Trainees greatly appreciate these manuals and report referring to them regularly.

The training manual is designed for both the trainer and the trainee. In using this approach, we save both money and time. There is also certainly less needless duplication and confusion about what materials are needed by the trainer when going out the door for their training session. This approach supports our adult training model, and also creates a more egalitarian teaching environment, because the trainer and trainees have similar training materials.

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The Training Agenda and How to Organize the Training Session

1. Setting an Agenda

Use the *Table of Contents* as your training agenda. The only additions you will want to make are a "Welcome and Introductions" at the top of the page and decide where "breaks" need to be anticipated. Because you can select your time frame for delivering the training program, decide how much time you need for the different areas of the training. As a rule of thumb, consider that each Lecturette and its supporting materials require at least 30 minutes to two hours to deliver.

These training programs are designed as one or two-day training sessions. This meets the need expressed by many professionals to receive training without losing a great deal of time from their work situations, often difficult for family and child welfare workers. Further, home providers such as group home workers, foster parents, proctor parents, and others can rarely take more than a day away from their home and families.

2. Welcoming and Introduction

The training program should begin with the *Welcome* and Introductions, giving each new trainee an opportunity to initiate their own process of contributing to and participating in the training. This is very important to fostering an atmosphere of joint learning with a higher level of trainee participation. Also, through the trainer's positive and receptive attitude, s/he can create an environment of trust and safety which goes a long way to optimizing the training process and maximizing the participant's growth and learning.

3. Training Competencies and Learning Objectives

After the introductions, present the *Training Competencies and Learning Objectives*. A valuable rule for trainers is to "tell people what you are going to teach them, then teach them, and end with a summary of what was taught." At this early point, the

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trainer should leave an opportunity for trainees to add any "training agenda" items they feel are important during the training program. This models an empowering process for the trainees wherein they too can "construct" the learning process that they feel they need.

At times, the requests of trainees go beyond the training program as designed. This is okay. The trainer must simply acknowledge the interest of the trainee, pointing out that the training will probably not be capable of delving in the specific area requested. This approach also helps trainers assess if "unique" issues exist that may be related to a geographic area, a local program, etc., or whether a trainee has a personal issue that may potentially distract the learning experience.

4. Training Content

The ***training content*** that must be delivered by the trainer(s) is provided in the ***Lecturettes***. The trainer must be very comfortable and knowledgeable about the material provided in each Lecturette. These training programs are also designed for a training team including a professional social work trainer and a foster parent co-trainer. This approach illustrates the valuable contributions of substitute providers who often spend a great deal of time with children in their home, and who often face problems that do not have easy solutions.

The training program is designed for adult learners. Therefore, in initiating the learning process, use of "lecture-to-the-audience" is limited. No Lecturette area should require more than 20 to 30 minutes of this talking to an audience style. Rather, the training exercise(s) in the manual serve to initiate the learning process. The use of ***exercises, videos, case vignettes, boxes, and discussions*** foster the teaching process as well as reinforcing central training objectives.

When presenting material in the Lecturettes, supporting ***charts*** exist that summarize the key principles, concepts, and points. The trainer can invite the trainees to "follow along" on a chart. These charts are very useful to keep the trainer focused. They are easy to read and allow the trainer the needed "notes" for delivering a portion of the training in its entirety.

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Though this training program is thorough in its presentation of central principles, concepts, skills, and supporting materials, the trainer(s) must have qualifications that include a strong practice background in child and family practice. This is a very important. It is, in fact, where the material in the Lecturettes becomes grounded in reality and relevance to the trainee. This is also the juncture where the trainer makes the training come alive. It is accomplished by the integration of trainer's own experience which--uniquely personalizes to the specific needs of *this* audience. The trainer's unique experiences infuse a personal and timely energy into the teaching process.

The training manual is designed so trainees have everything they need in the manual including paper to write on! The left hand side of the Lecturette sections provides the central ideas relevant to the learning area. The right side inserts instructions for when to introduce training exercises, videos, group discussions, etc. The right hand side of the manual also offers space for trainees to take notes and, importantly, for the trainer to make their own notes. Worksheets often exist for an exercise so time is not wasted in handing out materials once the training experience has begun.

5. Written Evaluation

Each manual also includes a ***written evaluation***, asking in essence, if the training competencies and objectives were adequately delivered. This strategy is used as an initial accountability assessment. It determines if the training as designed was in fact delivered to the satisfaction of the trainees. It is not possible, in one or two day formats to evaluate much beyond this point without using pre- and post-evaluative tools or other forms of behavioral evaluation which can assess improved practice competence.

Following these guidelines can best optimize the likelihood of creating a highly effective training for every participant!

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INTRODUCTION

The Education and Research Institute for Fostering Families is a specialized child welfare, adoption and foster care training program. Various important learning concepts related to families, youth and children are explored *within* the context of services to families and children and protective services more specifically. By paying particular attention to the multiple environments within which we work, Fostering Families' training is highly innovative and relevant for public and private sector caseworkers, case aides, and foster parent providers including group and residential care specialists. Fostering Families is also unique because faculty and foster parent training staff receive regular input from different parts of the social services system and from foster parent providers who work daily--to meet the needs of children *in out-of-home placement* and *at risk of removal from the family-of-origin*.

A primary goal of the training program is to examine different issues and intervention models in a relatively small group training experience. Each training program provides information that increases our understanding about the knowledge, concepts, and ideas that undergird specific aspects of practice and the skills to improve:

(1) the assessment and placement process with families and children at risk of placement or involvement in a family preservation program,
(2) the overall case planning, monitoring and supervising process, and
(3) the recruitment and retention of foster homes and other out-of-home providers.

Foster parents and caseworkers learn collaboratively in each session. Each training module is designed to motivate participants to go beyond transmission of information, to training opportunities created so that trainees can apply concepts either--in role play situations, small group experiences, group discussions, and/or--through individual activities. Participants are given the opportunity to integrate their learning through discussion and group experiences. Training sessions are scheduled regularly throughout the year and are each one-day sessions. To achieve high accessibility for foster parent providers, training sessions are often held on weekends. To afford access to caseworkers, sessions are also scheduled on weekdays. Each week training sessions are held throughout the urban, suburban and rural areas of the State.

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Introduction

Approaching the Trauma from Abuse of Families and Children is an important training program for caseworkers and family providers in the field of child abuse and neglect. How children experience the trauma in abusive situations varies, yet, we know that the effects of trauma are profound and lasting. Our work, after the trauma, often called the post-traumatic stress period, must be constructed to provide safety and reassurance. This is followed by a process promoting remembrance and mourning, and moving into the experience of reconnection and integration--for parents who care for children who are traumatic.

Georgia Rigg, Associate Professor at Colorado State University, and a long-time social work practitioner, has worked with abused and traumatized clients for over three decades. She teaches and presents her clinical approaches throughout the Western States. This training program stems from her wisdom and practice. Using psychodramatic processes along with such action therapy techniques as sculpting, storytelling, and role play, this training will help participants gain new understanding and approaches for working with abused children.

This manual is written to provide information on the concepts and issues we have discussed in this training. A Suggested Resources section lists some interesting reading related to this topic area.

In the training session it is unlikely that all the information provided will be entirely addressed. We recommend trainees read these materials soon after the training session. We have been told that this helps greatly in gaining a full understanding of the issue at hand.

We welcome you to this Fostering Families training session. We encourage you to participate fully in the training; ask questions that help you (and others) in this interesting and challenging learning opportunity. Colorado State allows participants the opportunity of earning continuing education credit (CEU's) or university credit. The training instructor will review procedures for applying for credit.

The best advise we can offer to work with today's agenda is to feel comfortable asking questions where helpful, get as relaxed as possible, and enjoy yourself!!

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NOTE TO PARTICIPANTS

As in many training program addressing abuse and trauma, the training participant must recognize how their own experiences influence how they respond to abuse and neglect. At times, the training may surface emotions which have been undisclosed and hidden. At any time, the trainer can provide support and help, though we know how important it is to seek professional help as well.

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TRAINING COMPETENCIES AND LEARNING OBJECTIVES

The primary purpose for designing this training program is to provide foster parents and caseworkers information and skills that will:

(1) enable them to better assess the needs of families and children
(2) make more appropriate treatment planning decisions
(3) carry out their professional roles in a manner that reflects greater awareness of and sensitivity to the effects of trauma on children.

1. Trainees will be able to define trauma, including Type I and II trauma.

2. Trainees will be able to recognize the role of boundaries in working with traumatized children and youth.

3. Trainees will describe approaches to helping foster safety and reassurance in children who have been seriously traumatized.

4. Trainees will be able to describe the model of intervention for traumatized children and youth presented in this training program.

5. Trainees will be able to describe several differences in treating young children and teens.

6. Trainees will be able to describe ways psychodramatic therapy and play therapy can be used to help children and youth work through the deeply lodged traumatic experiences.

7. Trainees will be able to describe how the assessment and treatment planning processes can be improved through the use of the model for intervention with traumatized children and youth.

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DEFINING TRAUMA
Lecturette 1

Everyday, we face challenges in our lives. Catching the bus, being on time for an appointment, finding out that your financial resources are shrinking--these and other living issues are part of daily living. *Crises* are different from everyday living problems. Crises hit when we do not expect them. Losing a family member, being seriously ill, losing a job, a house --these are crises. At these times, we need more energy, both physically and emotionally, to respond to crises, than we need to meet daily living challenges. We are very vulnerable in crisis situations.

Daily living challenges and crisis are different still from trauma. Trauma occurs outside the *normal* range of our living experiences. Events such as rape, terrorism, being caught in a serious fire or explosion--these are traumatic events. Trauma stays with us long after the event that was traumatizing.

Crises are everyday living problems that are different from trauma. Trauma is outside the range of normal experiences. Traumas stay with us; pictures around crises fade.

Dictionaries present definitions of trauma as stemming from two areas.

Individual and/or Group Activity:

During introductions, have each participant indicate

1) their name,
2) their role/position,
3) age of kids served,
4) the number of years they have been working with children and youth.

The trainer will keep track and come up a total number of years kids served, etc.

Comment on the shared wealth of the experience available in the group!

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Defining Trauma
Lecturette #1 (con't)

Random House College Dictionary (1992) defines trauma as:

(a) pathology - a body injury produced by violence or any thermal, chemical or other extrinsic agent;
(b) psychiatry - a startling experience that has a lasting effect on mental life; shock.

American Heritage Dictionary (1991) defines trauma as:

(a) medical - a bodily wound or injury especially one caused by sudden external violence;
(b) psychiatric - an emotional shock that causes lasting psychological damage.

A third dictionary, Webster's (1991) has these two components of a definition:

(a) medical - a bodily injury, wound or shock;
(b) psychiatric - a painful emotional experience or shock, often producing a lasting psychic effect, and sometimes a neurosis.

Bones knit, cuts and burns heal, and bruises fade. The external evidence of violence and the trauma become less visible, leaving perhaps only a few faint scars. Psychic trauma, however, lives on in the biological/emotional self, with scars every bit as pronounced as those of a third degree burn.

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Defining Trauma
Lecturette #1 (con't)

The task of healing psychological trauma is the focus of this training program.

Our understanding of trauma came initially from our work with soldiers in wartime situations. For example, in World War I, we "helped" "shell shocked" soldiers; in World War II we called it "combat fatigue." During the wars in Korea and Vietnam, it was termed "Post Traumatic Stress Syndrome."

Psychological trauma, as defined by Dr. Lenore Terr (1990), is a sudden, unexpected, overwhelmingly intense emotional blow or series of blows or assaults to a person from the outside (p. 8). This type of trauma is an affliction of helplessness and powerlessness. Abused children usually feel helpless and powerless when the parent, or non-related adult, inhumanely violates them physically and/or emotionally. For example, the abused child, who repeatedly is burned with a cigarette over days and days, months and months, sees the parent as "in control" and sees her/himself as helpless and fearful of the adult.

To live in this situation requires the implementation of a variety of defenses, all put in place to help the body endure, and the mind create meaning out of that behavior which is otherwise beyond understanding.

At the moment of trauma, the person is rendered helpless by the overwhelming forcefulness of the

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oppressor. In natural terms, a tornado can render people and a community as helpless because of its force and destructive power. When the force is natural, we say the event is a disaster such as a forest fire or a hard-hitting storm.

On the other hand, when the force is that of other human beings, we say the event is an atrocity. The holocaust, the abuse of children, infanticide --all of these are atrocities performed by humans --people who often look and act like ordinary people. The realization that humans can and do torture, rape, and maim those they profess to love, is itself traumatizing. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.

To examine psychological trauma is to come face to face with both human vulnerability in the natural world, and with the capacity for evil in humans. To study psychological trauma requires bearing witness to horrible events of humankind.

It is morally impossible to remain neutral in the role of witness to the conflict between the victim and perpetrator. Further, it is important to the healing of the survivor to know that the helper is willing to take a stand on the moral issue involved.

One point to make, in this initial discussion defining trauma, is to indicate that life stresses are

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not psychological trauma. Stress and crises are a regular, ordinary part of daily life. Traumatic events are not the daily stress of living events.

Rather, **trauma contains the important elements of intense fear, helplessness, hopelessness, loss of control, and threat of annihilation. Indeed, a key and necessary ingredient in trauma is the element of helplessness--the inability of the victim to stop or modify, in any way, the traumatic event!**

As the **DSM-IV description of Post-Traumatic Syndrome Disorder** indicates, the traumatic event is **"a psychologically distressing event, *outside* the range of usual human experience."**

For professionals, working in the field of child abuse and neglect, we come face to face with human vulnerability and the fact that we bear witness to human atrocities as part of the job. How *we respond* to this fact *affects how the client*--whether child or adult--*will move through this experience*.

Being traumatized may occur because of an inhumane experience, but being traumatized does not have to be a permanent condition. In this training program, we examine how to identify trauma and work with the traumatized child or parent. We hopefully succeed in bringing the person to a reconnection with their life and an integration of personal event(s)--so they can move on in their process of living and thriving.

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IDENTIFYING TRAUMA AND THE EFFECTS OF PSYCHIC TRAUMA

Lecturette #2

The key elements in any trauma are those of shock, terror, helplessness, and the element of being "out of the range of normal human experience." For example, we are all used to passing semi-trucks on the highway, and this becomes for us a "normal human experience." A semi-truck jackknifing on an icy highway, out-of-control and hurtling toward us, becomes an "out of the range of human experience" happening. We go through many reactions--too quickly to separate out at the time. These reactions include shock, terror, helplessness, fear, hopelessness, and our bodies may begin to shake, our hearts beat extremely fast, our breathing gets very fast, to name just a few.

The shock and terror of such an "out of the range of human experience" event is similar for the child whose parent, or equally trusted adult, suddenly turns on him or her in a screaming, hitting rage. Those reactions stem from within us and we will discuss these further in this section of the manual.

Type I Trauma

Type I trauma is understood as a single horrifying event experienced by a person(s). An auto accident, or an event such as the Oklahoma bombing of the federal building in 1995, are examples of Type I trauma.

Individual/Group Activity:

Examine Chart A entitled "Trauma Stops Time."

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We may find, in our child welfare work, a child who experiences a single horrifying event, resulting in significant impacts past the day of the occurrence.

Type II Trauma

Type II trauma, are understood as traumatic events repeated over a long period of time. Examples include soldiers experiencing bombing, etc., spouse abuse, and child abuse.

When protest, resistance, or escape is not possible, the human defense system becomes overloaded and options for enduring the trauma become narrowed. In Type II trauma, long-lasting changes in coping take place in adults and children. ***These changes impact the person's physical state, their available emotional responses, and their thought processes.***

In Type I trauma, the individual may be able, with a combination of time, nurturance, and support, to return to their level of functioning prior to the trauma.

In Type II trauma, the onslaught of physical or psychic blows is so continuous and devastating to the ego that usual systems of defense are torn into fragments. The person's energies go into attempting to repress terror and rage, and preserve a semblance of "normal" functioning.

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TRAUMA STOPS TIME !

Chart A

TYPE I TRAUMA:

One event--so horrifying to the person that it--replays and impacts everyday life!

Examples:
- Auto accident
- Oklahoma City disaster

TYPE 2 TRAUMA:

Repeated trauma over a long period of time; person tries to forget event(s); avoids reminders

Examples:
- War
- Captivity
- Domestic violence
- Child abuse: physical, sexual, and emotional

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Identifying Trauma and the Effects of Psychic Trauma

Lecturette #2 (con't)

The traumatized person begins to evidence symptoms of post-traumatic stress disorder. These symptoms fall into three main categories:

-hyperarousal
-intrusion
-constriction.

Hyperarousal

When in everyday life, a child or adult is faced with a terrifying event, the sympathetic nervous system prepares for "flight or fight." Adrenalin pours into the body system and the whole person goes into a state of red alert. In cases of psychic trauma, this state of hyperarousal does not abate, and the person remains in a state of permanent alert. Symptoms associated with this state of hyperarousal include:

(a) exaggerated startle response
(b) hypervigilance
(c) abnormal response to heat and cold
(d) need for "guarding the back" or positioning oneself in sleep or daily life so that no one can take the person by surprise
(e) poor sleeping patterns
(f) irritable and hostile with small provocation
(g) scanning faces.

Individual/Group Activity:

Examine Chart B entitled Typical Symptoms of Hyperarousal.

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TYPICAL SYMPTOMS OF HYPERAROUSAL

Chart B

Symptoms associated with the state of hyperarousal include:

* exaggerated startle response
* hypervigilance
* abnormal response to heat and cold
* need for "guarding the back" or positioning oneself in sleep or daily life so that no one can take the person by surprise
* poor, even terrible sleeping patterns
* irritable and hostile with small provocation
* scanning faces

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Intrusion

In cases of psychic trauma, time stops for a part of the person at the moment of the trauma. Memory of the event(s), when recovered or recalled, is that of a terrifying "instant replay," complete with all of the sights, smells, and sensations of the actual event. This replay intrudes into the person's life at unexpected moments, creating intense pain, fear, and discomfort. Such intrusions may occur as a flashback, a replaying of the event that literally hurls the person back in time--recreating the traumatic experience with ***all of the vividness and emotional force of the original event!*** Nightmares disturb the person's already poor sleep patterns. Traumatic nightmares may replay the whole event, or insert an element of the trauma into another dream. Whichever form the intrusion takes, the person wakes from sleep, heart pounding, often drenched in sweat, sometimes screaming, fighting and cursing.

Intrusion of traumatic material is so upsetting to the person that s/he will go to great lengths to avoid elements that may trigger a memory. Common triggers include: locations (both buildings and environments); smells; taste; sounds; sights; touch (particularly without warning and often out of the person's "neutral zones"); and lastly, references contained within movies, music, literature, novels, & conversation.

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Constriction

The third symptom of post-traumatic stress disorder deals with constriction, or "numbing out." During the experience of the trauma, the person may feel, in response to the extremes of terror and helplessness--a sense of depersonalization. The person may feel as if what is happening is taking place in a dream, not happening to him or her. They may have the sensation of watching what is happening from outside of their body. For the person, they will find it may be easier to "narrow" their life than to negotiate.

All of these altered states of consciousness help the person separate the self from the traumatic happening to the body. It is commonly called disassociation. Traumatized individuals, who cannot disassociate at will, may attempt to numb out through use of drugs, alcohol, sex, fighting, compulsive activities including bingeing on food, self-mutilation, etc.

The person goes to great lengths to avoid situations that may trigger memory and thus ordinary life processes become more and more restricted. Social isolation and attempted suicide may become more prominent behaviors.

All of these are attempts to find a haven from the effects of the trauma, either that which is currently taking place, or the memory of that which has happened. Gradually, the person spends more and more time avoiding *anything*

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that triggers memory. Thus thoughts, emotions, and behaviors get bound more and more tightly. Constriction becomes a way of life, not just a tool for surviving trauma.

Chemistry

The human nervous system is not composed of long uninterrupted lines of nerve cells but rather is a series of pieces of nerve fiber. Messages are passed across the synaptic gap(s) between the nerve fibers via several chemicals called neurotransmitters. As long as all is going well, information is transferred clearly and the system functions without problem(s). Messages pass to the "command posts"--information is processed, decisions made, behaviors chosen, and the system then clears in preparation for the next message.

Psychological trauma, however, alters some of these neurotransmitters, both in the victims body and in the victim's mind. Information does not flow smoothly. The victim does not function optimally in a crisis.

Epinephrine mobilizes the body to cope with the stress of the traumatic event. Cortisol, like epinephrine is released by the adrenal gland. It provides a source of energy to the body by releasing sugar into the bloodstream, and repairs body tissue in case of injury.

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Another by-product of adrenaline is Norepinephrine which is transmitted through the bloodstream to the brain, where it acts as a facilitator to the brain by enhancing alertness and efficient problem-solving.

Serotonin is a transmitter produced by the brain itself. When it is present and in adequate supply, the person presents themselves as calm, relaxed, and generally content. With a depletion of serotonin, a person becomes irritable, angry, unhappy and eventually depressed.

Endorphines are also found in the brain and are produced by the body. When actively circulating (during exercise), the person feels calm, relaxed, and often has a sense of well-being. A decrease in endorphine circulation may leave the person in an irritable, angry, unhappy state.

In the case of threat, the brain makes two immediate assessments--is the situation life threatening? and--what must be done to survive? The body responds to an affirmative determination of threat by producing a "flight or fight" response. All of the elements mentioned kick in to prepare and support the body for action.

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Identifying Trauma and the Effects of Psychic Trauma

Lecturette #2 (concl)

A particularly severe traumatic episode, or repeated episodes of abuse, decrease the presence of norepinephrine and the endorphins in the brain of the victim. In addition, severe traumatic stress also causes the neurotransmitter serotonin to be depleted. Depletion of these body chemical actions, through neurotransmitters, results in the onset of avoidant and constricting behavioral symptoms. For a variety of reasons, it appears that constant exposure to trauma and even the anticipation of threat, causes the production and flow of the neurotransmitters to become skewed. Some of these transmitters, particularly those associated with calming the person, are absent. Others, those associated with preparing the mind and body for flight or fight, are constantly present. The victim essentially *develops a case of chronic hyperarousal and can not relax*.

More than just a case of a person being tired or their "nerves being shot" is the reality that most all *other* bodily systems will be seriously and negatively affected through over use, lack of rest and recovery, etc.

Hyperarousal--with the body constantly on the go--creates persistent fatigue, tired muscles, bones, etc., making other "normal" human activities difficult, or sometimes impossible.

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STAGES OF EQUILIBRIUM AND DISEQUILIBRIUM

Chart C

Even	Break-Up	Calm	Withdrawal	Expansion	Transition	Equilibrium
2	2 1/2	3	3 1/2	4	4 1/2	5
5	5 1/2-6	6 1/2	7	8	9	10
10	11	12	13	14	15	16
16	17	18	19	20	21	22
22	23	24	25	26	27	28
28	29	30	31	32	33	34
34	35	36	37	38	39	40
40	41	42	43	44	45	46
46	47	48	49	50	51	52

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GENERAL EFFECTS OF TRAUMA ON CHILDREN

Lecturette #3

Children, especially young children, live at the mercy of their parents or other caretakers. It is important to keep in mind, that in the United States, more babies and young children die at the hands of their parents than are killed in car accidents, house fires, falls, or drowning! According to a recent Associated Press release, 2,000 children, aged 4 or younger, die each year. An additional 18,000 children are permanently disabled and 142,000 seriously injured.

For many children and youth, home is the place where the parent(s) who is (are) supposed to nurture, protect and love them. Instead, abusive parents "for no good reason" batter and/or sexually abuse them. To survive this, children must find ways to make some sort of liveable "sense" or meaning out of the situation.

Equipped with an immature system of psychological defenses, infants and small children try to find a sense of safety, trust, power, and control. For infants and children who are abused, and in a situation where none of these elements are available, they struggle to find ways to survive. These infants and children create behaviors which are predictable ways to persevere. We recognize that to preserve faith in the parents, and therefore sustain the primary attachment to them, these children must disbelieve the obvious, that something is terribly wrong with the parent(s).

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General Effects of Trauma on Children

Lecturette #3 (con't)

Children who develop in environments of domination and abuse develop intense attachments to those who abuse and neglect them. They will attempt to maintain these attachments no matter what the cost is in sanity and health. For example, a child will simply wall off the abuse from conscious awareness and memory. They just "forget" it. Or, the child will minimize, rationalize, and fabricate excuses so that the parent will not be seen as having committed the abuse. Another way children sustain their strong sense of loyalty, is that they try to keep the abuse a secret, even from themselves. They outright deny and suppress their thoughts and a wide variety of dissociative reactions emerge.

I'm bad, not my parent(s)!

When the reality of the abuse cannot be denied any longer, the child preserves the attachment to the parent by rationalizing that it is the child, ***not*** the parent who is "bad." This allows a measure of control to the child, because if the child can only figure out how to be good enough, act better, then the abuse will stop. The fact that no matter how "good" the child becomes, the abuse continues, only means to the child that he/she must try harder.

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General Effects of Trauma on Children
Lecturette #3 (con't)

Object constancy, the internalization of trustworthy and consistently dependable caretakers, allows the child to become safely autonomous. Since this process is repeatedly shattered by abuse, the child becomes used to operating out of a sense of a fragmented self. Such children have trouble with independence and have difficulty finding means for solace and comfort, or what is often referred to as self-soothing. As a child grows older, s/he may resort to a variety of means of self-soothing that are unacceptable and dangerous to themselves or others. These include: violently acting out, prostitution and solicited sex with peers, heavy use of alcohol or drug substances, self-mutilation, or running away and/or a combination of any of these other destructive behaviors. All of these behaviors serve the purpose of relieving unbearable emotional pain. These behaviors need to be seen as the means by which the child or youth regulates his or her internal emotional state.

The three major forms of adaptation that allow the child or youth to survive the abusive environment and preserve an appearance of normality are:

(a) elaboration of disassociative defenses
(b) development of a fragmented identify
(c) pathological regulation of emotional states.

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General Effects of Trauma on Children
Lecturette #3 (con't)

The Body Never Forgets
(*Energy--> Action--> Interaction*)

Most useful for our discussion on the effects of abuse on children and youth is the therapy developed by Al and Diane Pesso called psychomotor therapy. The theoretical base of this therapy is most useful in understanding the concept of memories and "knowing" that is locked in the very cells of the body. Though we can not review all the principles and concepts underlying psychomotor therapy, we can provide some basics that enhance our understanding of how children retain the memory of their abusive situation.

First, humans grow and develop, and then become human through their **interactions** with other human begins.

Second, all infants need a significant elder or adult to provide care, nurturance, support and appropriate limits. Thus, the child "borrows" competency from this caretaking adult until they are able to be competent on their own. Repeated interactions help the child "lock in" this sense of competency in the following way. The child's body experiences energy which can be physical tension, pain, joy, fear, etc. The action will have as its target, the significant adult who will provide the needed accommodation to complete the required interaction.

Individual/Group Activity:

Examine Chart **D** entitled "Understanding the Complex of Interaction and Validation."

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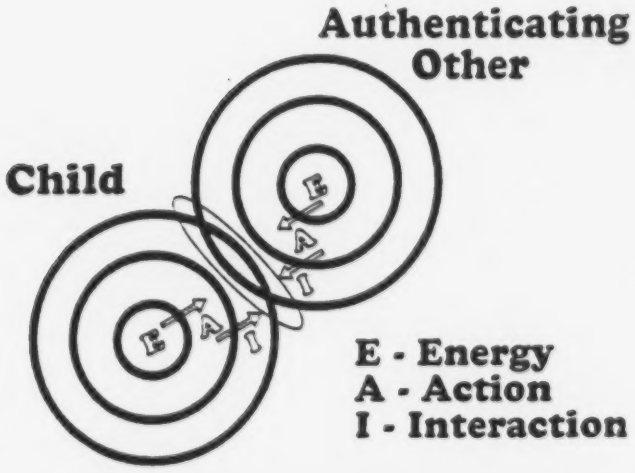
UNDERSTANDING THE COMPLEX OF INTERACTION AND VALIDATION

Chart D



Interaction with authenticating other provides primary validation gratification

Nurture
Support
Limits
Respect

The meaning of the interaction gets coded into a symbol - the symbol represents the meaning of the interaction

The symbol can be: Words, Smell, Taste, Sound, Visual, Touch, Emotion. Any part triggers the experience of the whole.

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General Effects of Trauma on Children
Lecturette #3 (con't)

Ideally, the **accommodation** will validate the reality of the child and will provide needed gratification. This validation message to the child can be simply stated as "you exist and your feelings and thoughts are real: and the gratifying message is "you can feel better, and I'll show you how to take care of yourself."

It is important to this concept to understand that, ***repeated experiences literally lock the message into the tissues of the child.*** Thus, the psychomotor realm of the child is affected. Humans are symbol-creating creatures and the meaning of the experience eventually is coded into a symbol. The symbol can be a word, a touch, sound, etc.

If all has gone well with the extensive series of interactive experiences of the child and the caretaking adult(s), the child will re-recognize the symbol at other points in their life and have a positive association. If however, the child has experienced primarily negative interactions, the symbol will cause the experience of the negative interaction to run. Because we lock experiences into our body, even the pre-verbal infant or toddler's body will remember interactions and related accommodations, even though the child has no words to describe what happens.

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General Effects of Trauma on Children
Lecturette #3 (con't)

Parents can usually understand the emotions and behaviors of their child when life has been relatively stable and predictable. When a child has been traumatized, their emotions and behaviors may be very difficult to decipher.

Emotional conditions that have their origins in traumatic experiences are known as **traumagenic states.** In planning the treatment for the child, the therapist can anticipate dealing with a series of responses by the child including self-blame, powerlessness, fragmentation, destructiveness, eroticization, dissociative identity disorder, and others. These are summarized on Chart E.

Defense mechanisms help people to cope and, under severe conditions, these mechanisms help a person to survive. A list of defenses typical with traumagenic states are identified in Chart F.

So which part is talking?

Eric Berne (1973) developed his theory of Transactional Analysis based on the study of observable ego states. As we know, each ego state is responsible for certain functions and behaviors of the personality and each speaks a certain language. The primary ego states Berne provided for our understanding are as follows and also appear on Chart E.

Individual/Group Activity:

Examine the Charts E and F summarizing traumagenic states and defense mechanisms.

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TRAUMAGENIC STATES
Chart E

Emotional conditions that have their origins in traumatic experiences are known as traumagenic states. When planning treatment for the child, the therapist can anticipate dealing with these traumagenic states. These are identified below with some clarification.

Traumagenic State	Example
Self-blame	"if" I was just a better kid"
Fragmentation of body experience	ability to disconnect from pain, hunger, etc.
Stigmatization	a deep sense of shame in one's core, being somehow different and fearing that others know the "secret"
Destructiveness	the wish to destroy the "bad self" is displaced to objects, animals, etc.
Eroticization	reaching for love and contact through sexual means--the only way the child feels of value
Attachment disorder	child does not trust the caretaking adult(s) enough to bond/attach
Susceptible to loss and betrayal	finds self in situations of loss in much of its young life or experiences many events of others taking advantage, betraying her/him
Dissociative identity disorder	child hides her/himself deep inside --splitting into multiple parts of egos

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SELECTED SET OF DEFENSE MECHANISMS
Chart F

Defense mechanisms help people to cope and, under severe conditions, these mechanisms help a person to survive. A list of defenses typical with traumagenic states are listed as follows.

Defense Mechanism	Description
Denial	a defense that cancels or negates external reality
Denial in fantasy	the person creates a fantasy that negates the awfulness of what really happened
Disassociation	self-induced hypnotic trance in which the person can cut off the physical and emotional pain of the experience
Displacement	redirecting powerful feelings or impulses toward an object less emotionally charged for the person
Intellectualization	the person masks disturbing instinctual wishes or external stresses with excessive abstraction or rationalization

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SELECTED SET OF DEFENSE MECHANISMS

Chart F (con't)

Defense Mechanism	Description
Projective identification	unconsciously attributes own memories, feelings, impulses to another; almost always involves the negative aspects of these elements
Splitting	allows the person to see the self or others as "all good or all bad"; the person who splits cannot integrate positive and negative qualities of self or others into full and cohesive images; occasionally the memories of one of these "selves" are lost to the person
Splitting of the object	the other person is split into good or bad; a common aspect of borderline personality disorder
Splitting of the self	the child considers the unwanted side a diseased appendage and tries to cut it off

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General Effects of Trauma on Children
Lecturette #3 (concl)

PARENT - The parent ego state is in place for the care of the self and others. Essentially, the parent nurtures, controls, leads, teaches, and scolds. Parent language includes lots of right and wrong evaluations, explanations of the right and wrong wants to think, feel and behave. Since the parent believes it knows what is right and best, it provides justification of behaving in certain ways for the betterment of the other person.

ADULT - The adult ego state is essentially a data base about how the world works. The adult uses lots of syllables to explain matter, but does so without emotion. Emotion is added from the child. The adult is basically a negotiator of the external world for the self.

CHILD - The child ego state is the feeling state of the personality. Berne talked about the natural or free child ego state as being the initial ego state we all experience as we enter the world. Very soon, we are asked to adapt to others, and part of this ego state then becomes the adaptive child ego state. We may find what is called the "over-adapted child ego state" when a child has to create such an elaborate set of thoughts and behaviors to control and survive in their immediate environment(s). The over-adapted child ego state is either that of the compliant child or the rebellious child. The child ego state likes bathroom words, swear words, and calls things "stupid" or "dumb" and uses lots of "feeling words."

Individual/Group Activity:

Examine Box One entitled "Understanding our Parent, Adult and Child."

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UNDERSTANDING OUR PARENT, ADULT, AND CHILD

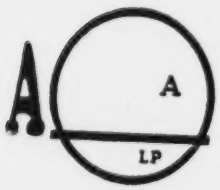
Box One

Based in the work of Eric Berne (1973), the notion that we each have an aspect of ourselves that is a parent, adult and child has popular acceptance in psychology. Below these states of being are illustrated and help us work with victims of trauma as the person begins to recognize these parts of themself.

Parent

N - Nurture
T - Teaches
L - Limits
C - Critiques

Value Systems Caretaking



Adult

A - Data Bank
LP - "Little Professor"
Intuitive Knowing

Problem Solving

Child

N - Natural
A - Adapted
OA - Over Adaptation
C - Compliant
R - Rebellious

Emotions Feelings

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ELEMENTS OF PSYCHODRAMA

Box Two

Created by J. L. Moreno (1946), psychodrama is a therapeutic process used throughout the globe. This process emphasizes approaches which maximize spontaneity and creativity in problem presentation and problem solution for the person in therapy. Often psychodrama is done with a group of people, so the person involved in their therapeutic work can draw on others to serve as the "actors," taking parts related to the story the person is re-telling. Although usually a group process, psychodrama really needs only a protagonist (the client), a director (therapist), a space to work in, and objects such as dolls and pillows that can represent different characters in a person's narrative or personal story.

In psychodrama the work is done on what is called the "stage." The client is identified as the protagonist. Moreno thought the word "patient" was stigmatizing and chose the term "protagonist" from classical drama. The therapist is labeled the guide or director. Again, Moreno sought to normalize the therapeutic situation into dramatic terms. The group, whether objects such as dolls, puppets, pillows, etc., or people, is the reservoir for the characters in the story. The group helps the client by playing roles as needed. At the end, the group shares. The person who is chosen to play a role in the protagonist's drama is called the "auxiliary ego" or "alter ego." If the auxiliary ego is to be directly confronted, the person playing this role is sometimes called the "antagonist."

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ELEMENTS OF PSYCHODRAMA

Box Two (con't)

In a psychodramatic action, the director helps the protagonist prepare to work through the process of "warming up", during which time the protagonist begins to tell the story of the problem. As the warm-up proceeds, the protagonist chooses auxiliaries to begin to take parts in the re-enactment of the problem. Through role-reversals and coaching the director helps these auxiliaries learn their roles and "lines" recognizing that the lines are actually from the protagonist. The drama is acted out in the here and now, offering immediacy and opportunity for a high level of catharsis. At some point, the protagonist experiences the peak of *abreaction*, the point where the protagonist has the greatest discharge of emotions. The balance of the drama is a process of "cool down" from the peak, ending with an extensive sharing from the group. Sharing is non-evaluative and is a means for members of the group to relate how the drama impacted their own "sense of self" and "self and others."

The core in the psychodramatic process is its emphasis on making explicit, through dramatic action, the issue or problem presented by the protagonist.

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DEMONSTRATION OF TRAUMA: VIDEO

Exercise #1

Instructions: Show a segment of the movie "Ordinary People." Have trainees consider the following:

1. What did you see in this movie segment?

2. Give examples that illustrate what has been discussed, to this point, related to trauma.

3. What was the professional's role?

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HOW ABUSED CHILDREN TELL US THEY HAVE BEEN ABUSED

Chart G

HOW DO KIDS TELL US THAT THEY HAVE BEEN ABUSED?

Well, sometimes they tell us in words. (Not often though, because this breaks the "Don't Tell" rule which is backed up by, "If you tell, I'll kill you, or kill your mother, or kill myself, or kill your brother, or sister, or your dog or kitten, and if ***you*** tell they'll put you in jail, or take you to a foster home, or . . . ")

Mostly, kids tell us in behaviors. Behaviors to notice may include some of the following:

* kids that have been outgoing and friendly become shy and sullen
* kids that have taken pride, or at least not minded, in being clean and neatly dressed, don't want to go near bathtub, wear their grungiest clothes, won't let anyone help them wash their hair, etc. (Keep in mind opportunities for cleanliness.)
* they set fires
* they become precociously interested in sex
* they attempt to initiate sexual behavior with other children on a consistent, almost driven basis
* they behave seductively with adults, rub against adult's genitals, breasts, etc.
* they go into rages
* they cry hysterically at the thought of going to Gramp's house . . . the baby-sitter . . . certain friends and relatives homes
* they play out their trauma in ritualized, grim, repetitive games
* they try to tell in vague terms--"I don't want to go to Scouts anymore" --"I don't like Mrs. Jones anymore"--"I don't want to play with the White's kids anymore!"

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HOW ABUSED CHILDREN TELL US THEY HAVE BEEN ABUSED

Chart G (con't)

* they begin stealing--money from their parents, things from around the house, --other kids prized possessions
* they are terrified to go to bed, and wake up screaming with nightmares
* they will sleep only with their backs to the wall
* they will always try to watch all adults all of the time
* they regress to babyish behaviors
* they bedwet or begin soiling themselves
* they don't want to eat--won't eat certain things that they previously would eat, or begin gorging themselves, often to the point of vomiting
* they don't want to be left alone--particularly in the house alone
* they may develop somatic symptoms--asthma, stomach problems, constipation
* they may begin having trouble in school--*keep in mind that for many abused children, school does represent the one safe place for them, and their school performance does not suffer*
* older children and teenagers begin to act out--disobey parents, get in trouble with neighbors, school authorities, police, etc.
* they become depressed
* they take drugs, drink, solicit sexual encounters
* they run away, get into fights with other kids
* they cut, burn, or otherwise mutilate themselves
* they act out on other children what was done to them
* they torture and kill pets and animals

They add two more rules to the "don't tell" rule, "don't think" and "don't feel." They Find ways to shut the abuse out of their minds, and relegate the pain to a part of them that has only the duty of feeling pain, and doing so in silence.

Remember, most abused children grow up, reach adulthood, and are ready to parent more children, with the secret of their own abuse hidden from the world, and intact.

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BUILDING THE CASE PLAN: UNDERSTANDING THE TREATMENT FOR TRAUMA

Lecturette #4

Assessment, case planning, and planning for the family are the most important tasks for the child protection worker responsible for the safety and care of the abused child and family. Generally, we believe the child or youth will be reunified at some point with their family of origin. Yet, to effect the best chance for success in the reunification, the caseworker must build case and treatment plans that heal the traumagenic state. The goal, in treatment of trauma, is to help the client become empowered and to function with age-appropriate behaviors. The client has to become capable of functioning autonomously. The model for this treatment is represented in three levels on charts in this section and is described in some detail in these next pages. Consider how each stage in this treatment process can be used to support choices for the case planning process.

Level One: Safety and Reassurance

Safety is vital to initiating the work of healing. The pain of dealing with the traumatic material may cause a child to flee into self-destructive behaviors. Thus, establishing an experience of safety helps the child recognize that their healing work can proceed.

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Physical safety: Abused children generally have little experience with consistently safe physical environments. For the victimized child, "out of control" is a way of life and this child has little reason to trust even their own thoughts, emotions, and bodies. Substitute care providers and workers must help the child gain control of their bodies. Daily bodily functions such as eating, sleeping, and exercise must be provided with structure and dependability. Work must focus on hyperarousal and intrusive symptoms, managing post-traumatic stress symptoms including control of destructive behaviors toward others and self-destructive behaviors.

Emotional safety: The creation and maintenance of an emotionally safe environment often exists in the licensed out-of-home care facility. This emotionally safe environment must recognize that procedures of questioning and information collection must not feel like an attack on the abused child. Information is owned by the child and should be given without coercion.

Whether addressing physical or emotional needs, prescribed medication should never be used as a punishment or reward for an abused child.

Social safety: Whether among adults, siblings, friends, or relatives, children who are traumatized

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through abuse and neglect should be supported with safety among social relations. For many of these children, allowing them to play unsupervised is not in their best interests. Structure short, safe play activities for the child with friends and siblings.

An important component of addressing safety for the child is to teach the child ways of self-soothing. This can include teaching them to use objects, even their voice as ways of self-soothing. Self-soothing techniques must be in alignment with the child's age. Some other self-soothing behaviors, for a small child, can be cuddling in a special blanket and napping, cuddling a special doll or stuffed animal, and seeking appropriate hugs from a primary caregiver. Self-soothing behaviors, with older children and teens, may include a special activity such as water painting, coloring, black line drawing, getting some hot chocolate, tea, etc. Visualization and other forms of self-relaxation, or a special form of physical activity, even a martial art program that teaches ways of self-control and self-care, can be excellent forms of self-soothing.

If consistent attention is paid to teaching self-soothing techniques and supporting the child as they use these methods, the hyper state of the child should diminish somewhat.

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Building the Case Plan: Understanding the Treatment for Trauma

Lecturette #4 (con't)

Reassurance

When working with abused children, it is important to remember that their experience of adults is one of tricks, betrayal, and abuse--physical, sexual, and emotional. The concept of a nurturing and protective environment is unknown. Words such as safety, trust and love have been used to deceive them. These words have been used to distort the child's reality--tricking them into accepting abusive situations, and keeping the family's wrong-doings secrets.

In trust-building work between the child and the significant others, such as foster parents, caseworkers, and therapists, it is important that the person demonstrate a sincere and deep willingness to understand the child's reality, not imposing him/herself on the child. The child can and will only express his or her feelings when they believe there is somebody available who accepts him or her fully and understands and supports them. We must recognize and remember that the child has survived living in environment(s) where the child's thoughts, feelings, and needs have been ignored and disregarded. Because of this state of deceit, the child's expectations are that s/he will be re-tricked, re-exploited, and re-abused by other adults in their life. They will attempt to maintain a known status quo rather than risk trusting an adult who "says" they will not exploit and violate them.

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Building the Case Plan: Understanding the Treatment for Trauma

Lecturette #4 (con't)

Thus, the adults, working with the child, must be very clear about the purpose of contacts with the child and must maintain clear boundaries. The child does not know that a positive way of interacting with others exists. Thus, it is the responsibility of these adults, working with the child, to help the child to both construct personal physical and emotional boundaries, and to learn to respect other's boundaries, including the "edges" of those boundaries.

Physically and sexually abused children have had no control over their bodies and have been able to assume power only by accepting responsibility for their own abuse. It is very important that the therapist provide a safe structure for therapeutic work. It is equally true that the caseworker find an environment that offers safety for the child when working together or visiting.

When working with the child, rules are okay! Within the safety of clearly stated limits and working conditions, the child can relax their ever-present state of hypervigilance. They can thus prepare for the next level of work to be done, namely, remembering and re-enacting the abusive experience(s).

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Clear statements must be offered such as:

"My name is . . ., my job is about . . .,"
"What we will do together is . . ."
"Where we will do this work is . . ."
"Your part of this work, when you are ready, is . . ."

The work of reassurance takes time. Reassurance is on-going as well. For every "secret" or horror the child presents, acts out, draws, etc. we must expect there are very intense emotional responses such as self-punishment, rage, self-abuse, etc.

A well of patience is the best resource for everyone who wants to help the traumatized child heal.

Level Two: Remembering, Reenactment, Abreaction, Accommodation

With time spent building safety and reassurance, a child may reduce their angry and self-destructive behaviors. This does not mean the work is done. All too often, the transition to more compliant behavior, even less destructive behaviors by the child, is thought to be the "sign" of having been healed or "fixed." This is not so. Part of our

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wanting to believe this stance is because asking an abused child to re-enact and remember their experiences of abuse seems like an exercise in re-traumatizing the child. This is not true if we have adhered to the first level work described previously. Experts throughout the field of trauma work, including those working with traumatized children, recognize the importance of taking the abusive situation and getting it "out of the body" so to speak. As long as the horrific experience remains lodged in the child's psyche and physical body, the child is still traumatized, suffering in the traumagenic state.

Remembering begins with listening, listening to the unspeakable and unthinkable. Over time, workers in child protective services and long-term foster parents learn a great deal about the horrors children experience. We must listen carefully, fully, and quietly as children tell us what they have experienced.

The in-depth work of remembering, re-enactment, abreaction, and accommodation should be done by a therapist skilled in working with traumatized children and youth. It is important however, to recognize that caseworkers and substitute parents (foster parents and proctor home providers) must be aware of the movement and progress of this therapeutic process, and be of help, if requested by the therapist. Again, this is where the

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caseworker must recognize the importance of planning for this phase of work, allowing the needed time for the therapy to move forward.

In this level two work, the child needs to tell the story of the trauma, completely, in depth and detail. Not as if for court testimony, rather, to be able to release each action of the abusive event. In reconstructing the traumatic event, the traumatic memory can then be integrated into the person's life story, becoming narrative, not a repeated episode. Using psychodrama principles of making a problem or issue explicit through action, the child's story becomes externalized, concretized, abreacted and accommodated. Each of these actions will be discussed briefly.

Externalize and concretize the story: Abused children carry horror movies within them. Much of their energies go into trying to suppress their movies. They deny, rationalize, and repress the realities of what has been done to them. The first step, in the cathartic process necessary for healing, is to find a way to help the child move the traumatic event from inside themselves to outside themselves.

Some ways to do this include using:
artwork (magic markers, crayons, paints, charcoal, blackline, computer graphics, etc.),

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sculpture using clay, sand, play dough (if the child can tolerate the consistency),
doll house and dolls,
toys for creating worlds,
writing (journaling, story writing, poetry, etc.),
music (relaxation tapes, video music tapes, etc.),
puppets and story-telling.

In the earliest stages of this work, the therapist must underline, over and over, that the child is not to blame for what happened. "It's not my fault" becomes a vital point of transition for the child. Body awareness work is also important in these early stages, and continues to be an awareness point. Many abused children have frozen themselves physically and need help learning to move more freely. Supportive activities that can be provided by caretakers include dance lessons, running and jogging programs, swim lessons, and other sport programs. As work is done to thaw out the body, frozen feelings are melted as well. As feelings emerge, it is vital to provide names for feelings, so the child can create an emotional vocabulary with which to live.

Abreaction and accommodation: We define abreaction as the process of relieving a repressed emotion by talking about it. In trauma work, abreaction involves the release of stored pain and emotion(s) through a whole body experience. In

Individual/Group Activity:

Either in groups or individually, read the children's story provided by the trainer.

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this phase of work, the goal is to add the emotional component to the material that has been externalized and concretized through the telling of the story. This work is aimed at bringing the memory of the traumatic experience into the here and now. This is hard work for everyone--child and therapist alike. The child must confront the terror, rage, and helplessness of the experience. The therapist must act as the witness to the atrocity. Abreactive therapy is hard, dirty, rough work. Terror has a sound like no other. No matter what the age of the client, in the telling of the story, the trauma becomes testimony.

Some approaches that move the child through the process at this point include mini-drama and play therapy. For example, if a child is old enough, maybe 12 or older, writing out a script of what happened, including the elements of the context, the facts, emotions, and meanings can be done.

The youth then narrates the story to the therapist and group (if available), bringing the situation into the here and now. The therapist encourages the fullest expression of feelings possible. This can then be set up as a mini-drama. When using the mini-drama approach, it is important to have the youth "work at a distance." A doll or pillow can "hold a place" for the youth when the child is

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enacting events when they were very young. A group member can play a part when the child is older. The youth can relate the trauma and prescribe both the appropriate recompense for the abuser and receive accommodation from the group and the therapist. This process of recompense and accommodation normalizes, validates, and provides a sense of comfort and self-determined fairness for the victim.

Play therapy (abreactive play therapy) can be used when the child is young, or a group is not available. Key to this play therapy, the therapist must provide a safe environment for the child to fully express all emotions. At the end of the child's work, the therapist must again provide appropriate validation and gratification. Further, it is recommended that a session of abreactive therapy be followed by sessions that "put edges around the work" through discussion and construction of a new story, an integrated self-narrative. Hypnotherapy is not recommended as these children are very competent as self-hypnotists. The therapist can, however, have the child visualize desired outcomes in daily interactions, as well as visualize safety and plan how to obtain it.

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Building the Case Plan: Understanding the Treatment for Trauma

Lecturette #4 (con't)

Abreactive work offers the child or youth the opportunity to feel his/her feelings and have them appropriately labeled. As the abreactive work proceeds, the child can be directed to give up the re-enactment games and inappropriate clown-like and jokester behaviors, which have previously served the purpose of "bleeding off" the traumatic tension.

The resolution of trauma allows the child to experiment with more flexible, developmentally appropriate behaviors. On-going work will help the child learn appropriately assertive behaviors as well. With successful treatment, the words "yes and no" become indications of preference, not potential traps leading to abuse and betrayal.

Mourning and Integration:

The drama is over. The story has been told. All trauma work involves loss. In the case of abused children, the losses are often profound. Loss of innocence, loss of time, loss of childhood itself are some. Eventually the healing process must deal with the grief involved in all of these losses. At this stage, the client fluctuates from rage to tears, and often feels that they are losing what progress they have made earlier. This is a vital

Individual/Group Activity:

Examine the charts identifying the "Central Principles for Working with the Traumatized Child,' and, "Criteria for the Resolution of Trauma."

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point for the therapist to work with "manageable bits," apportioning time segments to help the child "re-write" their story in a way that is integrative of their entire self. Over and over, the therapist must reassure the client that their feelings, often overwhelming for them at this point, are natural, normal, and these feelings will subside with the continued healing that is taking place. The goal is to heal to the point where the child or youth can make their own choices and directions because they are an intact, in control person, with all the capabilities to plan for their near and farther future.

Techniques in this stage can include using stories and metaphors that present pictures of integration and completion. Integration means representing how a person puts things together as a whole. There is an ownership in integration. Completion represents having done something, and there is a choice to be made. Completion suggests to the child or youth that they are "over" being a victim. Reclaiming all of the lost parts of the self, and recombining these parts into a smoothly functioning whole person--is the goal of integration and completion.

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Lecturette #4 (con't)

Mourning is an emotional process of responding to loss. Resistance to mourning is not unusual, based both in cultural messages and family messages. Resistance to mourning can be seen in children and youth who spend a great deal of time in revenge fantasies. Many of these fantasies *are* frightening to hear. This resistance masks the need for intense catharsis of rage. When this release of rage can take place, the client can move from fury to righteous anger and to placing blame and "badness" where it belongs . . . on the perpetrator!

Children need to grieve not only their own loss of innocence, trust, and autonomy, they also mourn the loss of their belief in the myth of having had good parents. This is one of the hardest and saddest elements for the child to relinquish.

For a time, the client appears to believe that s/he must mourn forever, to be a "child of sorrow." This is the time for the therapist to trust that the --hidden health within the child will be stronger and this healthy sense of well-being--will become more important to the child than the "cavernous sorrow" they perceive inside themselves.

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Building the Case Plan: Understanding the Treatment for Trauma

Lecturette #4 (concl)

New Connections and Integration:

If the treatment work of the past trauma(s) is successful, the client, no matter what age, must face the task of creating their future. Having lived in an atmosphere of dictatorship-like control, the child may find freedom of thought and control of their bodies as both a delight and a challenge. The victim of long term physical and/or sexual abuse must enter an educational phase guided by a simple phrase, "Think of what you want, not what you fear." Here, substitute caregivers must work with the therapist to support this process of connection and integration. It is vital that the child have access to adults with good information about the world. The child must also have access to peers who will help them be in the world successfully. Children and youth benefit from connections with other youth who can help them confront and deal with issues about living as a survivor, no longer a victim. There are support group programs that may be helpful.

Finally, treatment for victims of severe and/or chronic abuse need to have an "open door" idea about therapy. As the child or youth move through different developmental stages, they may need to "re-feel and re-tool" themselves.

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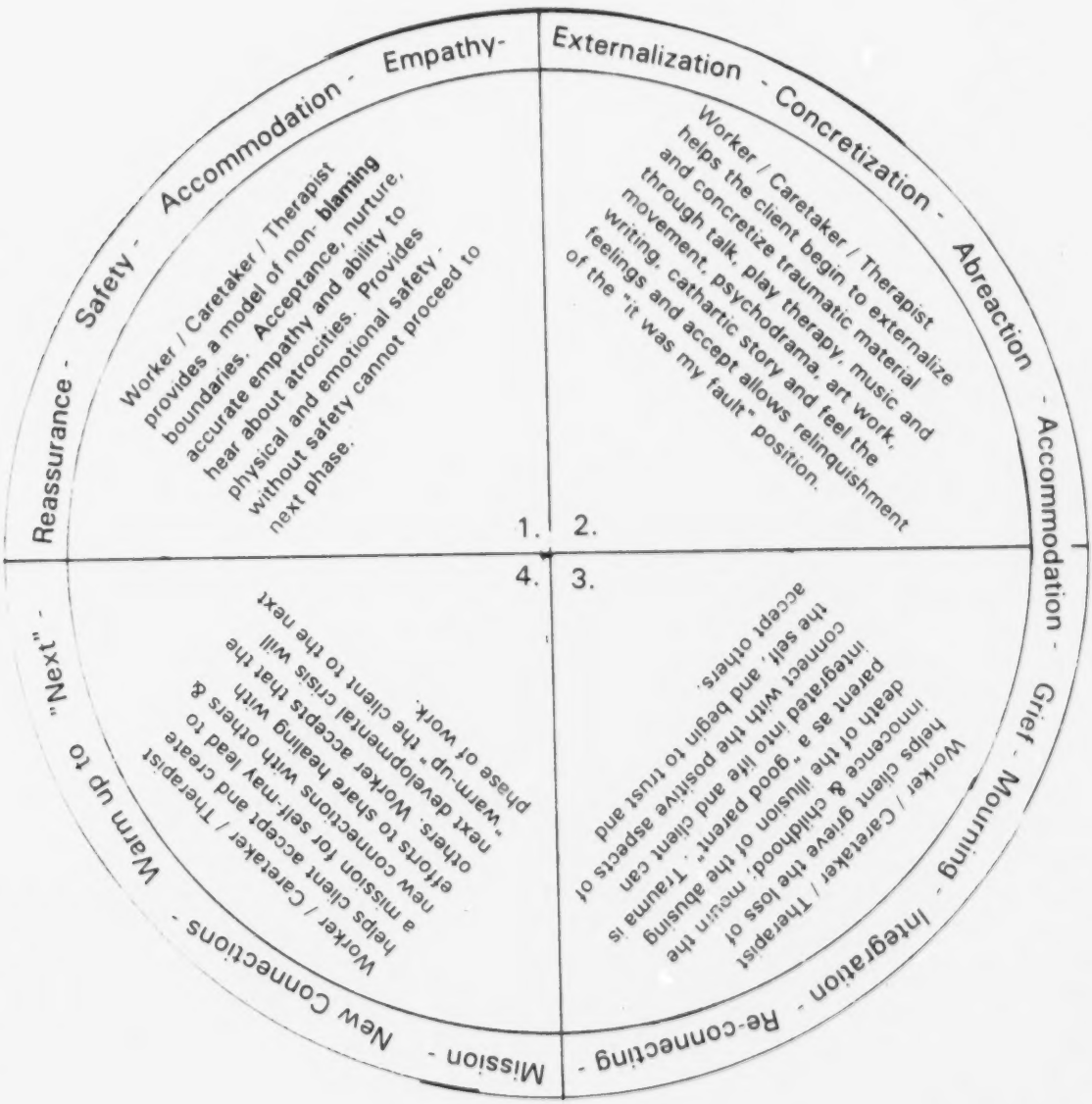
TREATMENT WHEEL

Chart H


Reassurance - Safety - Accommodation - Empathy-
Worker / Caretaker / Therapist provides a model of non-blaming boundaries. Acceptance, nurture, accurate empathy and ability to hear about atrocities. Provides physical and emotional safety. without safety cannot proceed to next phase.
1.
Externalization - Concretization - Abreaction - Accommodation - Grief - Mourning - Integration - Re-connecting -
Worker / Caretaker / Therapist helps the client begin to externalize and concretize traumatic material through talk, play therapy, music and movement, psychodrama, art work, writing, cathartic story and feel the feelings and accept allows relinquishment of the "it was my fault" position.
2.
3.
Worker / Caretaker / Therapist helps client grieve the loss of innocence & childhood; mourn the death of the illusion of the abusing parent as a "good parent". Trauma is integrated into life and client can connect with the positive aspects of the self, and begin to trust and accept others.
4.
Mission - New Connections - Warm up to "Next" -
Worker / Caretaker / Therapist helps client accept and create a mission for self-may lead to new connections with others & efforts to share healing with others. Worker accepts that the next developmental crisis will "warm-up" the client to the next phase of work.

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CRITERIA FOR THE RESOLUTION OF TRAUMA
Chart I

1. The physiological symptoms of post-traumatic stress disorder such as poor sleep patterns, serious behavior problems, etc., have been brought within manageable limits for the child or adult.

2. The child or adult is able to bear the feelings associated with the traumatic memory(ies).

3. The child or adult has authority and thus control over her/his memories. S/he can elect both to remember the trauma and to put the memory aside.

4. The memory of the traumatic event is a coherent narrative, linked with feelings for the person.

5. The person's damaged self-esteem has been restored.

6. The person's important relationships have been established or new relationships provide the support, nurturance, and love necessary for positive growth and development.

7. The child or adult has reconstructed a coherent system of meaning and belief that encompasses the story of trauma and allows the person to move on in the new construction of meaning and beliefs.

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CENTRAL PRINCIPLES FOR WORKING WITH THE TRAUMATIZED CHILD

Chart J

Examine the principles identified below in preparing the child for their entry to healing. These will be reviewed in various parts of the training.

Be clear and provide explanations that support the child.

Help the child understand the purpose of your work together; the purpose of each meeting or session together; clarify why it is necessary to slowly and carefully examine what has happened to them.

Educate the child the best you can about any special areas that will occur because of their abuse situation such as court appearances, medical intervention, surrogate or foster care, etc.

Rules are okay when working with the child. Use these rules to support healthy limits and ways of working together.

Therapeutic work must help the child to re-create, "pressure cook," and integrate the traumatic experience(s).

Help the child re-create the traumatic experience in play and fantasy, with the aim of providing an arena where they can become victors rather than victims.

Help the child "pressure cook" the experiences into words, and to find words to acknowledge and express their own feelings, thoughts, and behaviors related to the events that were traumatizing.

Help the child accept the reality of the experience(s), neither exaggerating or minimizing the significance of what happened.

Help the child place the experience(s) as part of his/her life narrative, not as a fragmented episode.

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CENTRAL PRINCIPLES FOR WORKING WITH THE TRAUMATIZED CHILD

Chart J (con't)

Listen to the child's words carefully. Do NOT correct their words, or how they create their narratives. Appreciate the story as it is told.

Throughout the process, build a future so she or he can have a successful, full life.

Help the child re-connect with their self and others in nourishing, age-appropriate ways, and take an active part in planning a future with the child.

Support experiences that foster their self-esteem.

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USING STORIES
READING TIME
Exercise #2

INSTRUCTIONS: In small groups, have trainees share in the reading of a children's book entitled *The Unicorn and the Lake.* This reading can be done by one of the group members, two members may share in the reading, or each group member may read a page and then pass the storybook to the next. After reading the book, respond to the following questions:

1. What does the story evoke for each of you?

2. What happened for you when you heard the story?

3. What would we want an abused child to get from hearing this story?

   What metaphors and themes are possible?

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EMPATHY
Exercise #3

INSTRUCTIONS:

Step One:

The trainer asks training participants to stand up and move into an area where people can stand in a circle. The trainer should ask trainees to get into pairs. It is probably best if partners are people who do *not* know each other really well.

Step Two:

The trainer then asks trainees to do the following:

Take several minutes to show your partner, without words, how you want someone to hold your hand to comfort you.

Step Three:

When that is completed, the training group should consider the following questions:

1. What was this like for each of you?
2. Why is it difficult to not talk when doing this?
3. What opportunities exist to talk to children about touch by initiating this type of activity?

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BACK TO BACK
Exercise #4

INSTRUCTIONS:

STEP ONE:

Get into pairs, preferably with someone you do not know. Move into a "back to back" position. Lean against each other so that you are comfortably balancing each other--supporting each other with no extensive effort.

STEP TWO:

Consider the following questions:

1. Did everyone achieve this balance?
2. How did this feel?
3. How did the adjustments occur?

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EXTERNALIZATION: A CRITICAL GOAL OF TRAUMA RESOLUTION

Exercise #5

INSTRUCTIONS: This role play demonstration is based on a scenario focused on spanking. The trainer asks for three volunteers to demonstrate this experience of trauma for a young child.

Child:

7 year old boy was given "the belt" in the shed by the house.

Role Play Child:

Takes the position the child describes

Role Play Adult:

Takes the position of the parent who did the "belting"

The trainer instructs the child to describe how he was positioned when he was being "belted." The role play child then gets into that position. The child then describes how the adult stood and positioned her/himself when they gave the "belting."

The trainer then asks these role players to re-enact this "belting." In doing this, the child who set this up is watching this role play. The actual "belting" is not actually performed, rather, the role plays use a book and "hits" the book to enact the sound of being "belted."

After this short role play, the trainer asks the child to reflect on the scene. Then, the trainer asks the child to watch the scene again, and this time the child is to go over and stop the parent.

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EXTERNALIZATION A CRITICAL GOAL OF TRAUMA RESOLUTION

Exercise #5 (con't)

After the second re-enactment, the trainer asks the child what this experience was like.

The trainer asks for feedback from the entire group. Questions, such as those which follow, can be used to process this exercise:

1. How can we help children in placement who hold these kinds of trauma experiences?

2. How do these stages of re-enactment move the child toward greater calmness?

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THE STAR SYSTEM
Exercise #6

INSTRUCTIONS:

The trainer asks for 5 trainees willing to demonstrate how a traumatized child might hold their splintered self. This is demonstrated by asking one person to stand in the center of the room. Around this person, have the four others position themselves as if in the four directions, sitting at the foot of the person in the center.

The trainer describes this "star system" of a person. The one "ego" at the foot of the standing person is a 2 year old child who was thrown against the wall by her mother so many times that she was removed at that age and placed in a foster home for one year. The second "ego" is a 3 year old who was raped by a foster child. The third "ego" is a 10 year old who was raped by her step-father (when she was returned to her mother). the fourth "ego" is the 13 year old who is mad, ready to beat up anyone who gets out of line!

The trainer than asks the person standing what this experience feels like. She asks what this would be like if this was the child she had in her home?

The trainer than asks the four people who represent the different splintered egos to describe how they feel having been given their unique history? What happens when someone feels such ragefulness?

The trainer then asks for comments and feedback from the

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SUGGESTED RESOURCES AND MATERIALS CITED IN THIS MANUAL

Axline, Virginia M. (1947). *Play Therapy*, New York: Ballantine Books

Berne, Eric (1973). *Games People Play: The Psychology of Human Relationships*. New York: Ballantine Books.

Blatner, H. (1973). *Acting in: Practical Applications of Psychodramatic Methods*. New York: Springer.

James, Beverly (1989). *Treating Traumatized Children: New Insights and Creative Interventions*. Massachusetts: Lexington Publishers.

Moreno, J. L. (1946). *Psychodrama*. New York: Beacon House.

Pesso, Albert (193). *Experience in Action: A Psychomotor Psychology*. NY: New York University Press.

Tedeschi, Richard and Lawrence Calhoun (1995). *Trauma and Transformation: Growing in the Aftermath of Suffering*. California: Sage Publications.

Tarr, Lenore (1990). *To Scared to Cry: How Trauma Affects Children and Ultimately Us All*. New York: Basic Books.

Salter, Anna C. (1995). *Transforming Trauma: A Guide to Understanding and Treating Adult Survivors of Child Sexual Abuse*. CA: Sage Publications.

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SUGGESTED RESOURCES: CHILDREN'S BOOKS

Bunting, Eve (1990). *The Wall*, New York: Clarion Books.

Johnson, Tony (1994). *Amber on the Mountain*, New York: Dail Books for Young Readers.

Mayer, Marianna (1982). *The Unicorn and the Lake*, New York: Dail Books for Young Readers.

Mayer, Mercer (1983). *I was so Mad*, New York: A Golden Book.

Mayer, Mercer (1968). *There'sa Nightmare in my Closet*, New York: Dail Books for Young Readers.

Mayes, Susan (1993). *The Usborne Book of Dinosaurs*, London, England: Usborne Publishing Ltd.

Miles, Miska (1971). *Annie and the Old One*, New York: Little, Brown and Company.

Morris, Winifred (1990). *What if the Shark Wears Tennis Shoe?* New York: Aladdin Paperbacks.

Naylor, Phyllis Reynolds (1994). *King of the Playground*, New York: Aladdin Paperbacks.

Viorst, Judith (1972). *Alexander and the Terrible, Horrible, No Good, Very Bad Day*, New York: Aladdin Paperbacks.

Williams, Margery (1989). *The Velveteen Rabbit*, New York: Dover Publications.

Wood, Douglas (1992). *Old Turtle*, Michigan; Pfeifer-Hamilton Publishersy

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Education and Research Institute for
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Application for Partial Credit
Trauma

Name: _____ Social Security #: _____

Address: _____ Phone: _____

_____ Date: _____
(city) (state) (zip)

I. Application for Partial University Credit

Grading: Pass/Fail

The Social Work Department at Colorado State University will grant university credit for each six different modules of training completed. Applications for credit must be made at the Time of Each Module Training ONLY. All work carried out in the modules must meet general academic standards of Colorado State. Written materials must be submitted and receive satisfactory grading for credit to be awarded. These applications will be held until the applicant completes his/her sixth module training. At this point, s/he will be able to formally register through the Division of Continuing Education for 1 credit hour at the current tuition rate set by the University.

_____ Yes, I wish to apply for University credit.

II. Application for Continuing Education Units (CEU's)

Colorado State University, Division of Continuing Education, will grant Continuing Education Units (CEU's) for successful completion of this training session at a cost of $18.00. If you wish to apply for these units, complete the above information, attach a check made payable to CSU, and return this application to the trainer.

_____ Yes, I wish to apply for Continuing Education Units (CEU's) today.

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ASSIGNMENT FOR PARTIAL CREDIT

Imagine you are either a worker for or a substitute parent provider (foster parent or proctor parent, etc.) who has responsibility for an 7 year old girl who has been sexually abused and physically abused for the last 4 years by both mother and her live-in boyfriend. Type or neatly print responses to the following questions.

1. Is this type 1 or type 2 trauma? Why?

2. What kinds of behaviors might this young girl exhibit?

3. Describe how you might go about establishing safety with this young girl when you are with her.

4. Discuss how play therapy might be used with this young girl?

5. What would elements of an ideal case plan include?

6. Discuss a child or teen who you have worked with or had in your home who you believe was seriously traumatized. What signs led you to recognize the trauma? Was the case plan adequate to help her with her trauma? What did you see working for the child? Was there history of trauma in other family members?

7. Feel free to include any other thoughts or comments that you want to add.

Please mail this completed
assignment to:
Dr. Mona Schatz
Associate Professor/Director
Education and Research Institute for
FOSTERING FAMILIES
Colorado State University
112 EDUCATION BUILDING
Ft. Collins, CO 80523

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FOSTERING FAMILIES

Education and Research Institute

APPROACHING THE TRAUMA FROM ABUSE OF FAMILIES AND CHILDREN

Evaluation By Participants

The following items are designed to assess your satisfaction with the training as well as the effectiveness of the training design and materials. Please use the following scale and circle your response.

1 - not well addressed in the training
2 - not as adequately addressed as necessary
3 - adequate; given sufficient attention
4 - well addressed in the training
5 - very well addressed in the training

1.	Trainees will be able to define trauma, including Type I and II trauma.	1	2	3	4	5
2.	Trainees will be able to recognize the role of boundaries in working with traumatized children and youth.	1	2	3	4	5
3.	Trainees will describe approaches to helping foster safety and reassurance in children who have been seriously traumatized.	1	2	3	4	5
4.	Trainees will be able to describe the model of intervention for traumatized children and youth presented in this training program.	1	2	3	4	5

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FOSTERING FAMILIES

Education and Research Institute

APPROACHING THE TRAUMA FROM ABUSE OF FAMILIES AND CHILDREN

Evaluation By Participants

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1 - not well addressed in the training
2 - not as adequately addressed as necessary
3 - adequate; given sufficient attention
4 - well addressed in the training
5 - very well addressed in the training

5.	Trainees will be able to describe several differences in treating young children and teens.	1	2	3	4	5
6.	Trainees will be able to describe ways psychodramatic therapy and play therapy can be used to help children and youth work through the deeply lodged traumatic experiences.	1	2	3	4	5
7.	Trainees will be able to describe how the assessment and treatment planning processes can be improved through the use of the model for intervention with traumatized children and youth.	1	2	3	4	5

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B. The following items relate to program aspects of the training module. Please rate these items on the following scale. Any additional comments are welcome in the space provided after the question.

1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Very Good

	Very Poor	Poor	Adequate	Good	Very Good
1. The length of the training (Was the material covered in the time allotted?)	1	2	3	4	5
2. Usefulness of training manual	1	2	3	4	5
3. Participant responsiveness	1	2	3	4	5
4. Your ability to participate expressing your ideas, feelings, and concerns	1	2	3	4	5
5. Your interest in the training session	1	2	3	4	5
6. Your comprehension of the material presented	1	2	3	4	5

COMMENTS: Please be specific:

C. We are interested in your feedback about our trainer, co-trainer(s). With this feedback we can continue to improve our sessions.

1 = Totally inadequate and ineffective
2 = Generally inadequate and ineffective
3 = About half and half
4 = Usually adequate and effective
5 = Highly adequate and effective

	Totally Ineffective/ Inadequate		0		Highly Effective/ Adequate
1. Knowledge/mastery of the subject matter	1	2	3	4	5
2. Preparation	1	2	3	4	5
3. Ability to communicate	1	2	3	4	5
4. Style of presentation	1	2	3	4	5
5. Enthusiasm/interest in subject matter	1	2	3	4	5
6. Overall performance	1	2	3	4	5
7. Ability to facilitate	1	2	3	4	5

8. In general, what would you identify as the strengths of trainer(s)?

9. In general, what would you identify as the deficiencies of trainer(s)?

D. The training setting is obviously an important aspect of a sessions success. We are interested in your feedback regarding the location, room, etc., and again welcome any comments or suggestions.

	Very Poor	Poor	Adequate	Good	Very Good
1. Setting appropriate for concentration, i.e., distraction, noise, temperature.	1	2	3	4	5
2. Setting conducive for participation	1	2	3	4	5

COMMENTS: Please be specific:

E. Overall Comment: What could have been done differently to make the training sessions more beneficial or helpful to you? (Please use back of page if necessary).

I.D. #_ _ _ _

FOSTER CARE DEMOGRAPHICS

E. **DIRECTIONS: Please fill in all blanks with information where needed or circle the correct number where several choices are provided on the next two pages.**

1. Last 4 #'s of Social Security # _ _ _ _

2. Circle correct role: 1. worker 2. foster parent 3. Other_____
(please specify)

3. Date _ _ - _ _ - _ _

4. County _____

5. Circle gender: 1. Male 2. Female

6. Circle racial background:
1. Hispanic
2. Black, not of Hispanic origin
3. Asian-American
4. American Indian
5. White, not of Hispanic origin
6. Other:_____

7. Age_____

8. Are you (please circle one): 1. Married 2. Separated 3. Single

9. Number of birth & adopted female children_____

10. Number of birth & adopted male children_____

11. Circle age group of birth & adopted children:

1. all under 5
2. all under 10
3. all under 15
4. all under 18
5. all over 18
6. some under 18 & others over 18
7. none

12. Highest level of formal education: (please circle one)

1. some high school
2. high school graduate
3. some college
4. college graduate
5. Master's degree or higher

13. Within the past year, have you participated in any other foster care training other than Colorado State's Fostering Families?
1. yes 2. no

Thank you for your help! Your feedback is important for our continuing improvement of the Fostering Families project.

PLEASE CONTINUE TO THE NEXT PAGE

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F. **DIRECTIONS: Finally! Complete only the section which refers to you as either a Foster Care Parent or Foster Care Worker.**

FOSTER CARE PARENT SECTION

14. What type of agency are you employed or licensed through?

1. County Department of Social Services
2. Private Child Placing Agency (please specify)_____
3. Both County Department of Social Servoces and Private.
4. Indian/Tribal
5. Other please specify) _____

15. Total # of children presently in home_____
16. Number of foster female children_____
17. Number of foster male children_____

18. Circle age group of foster children:

1. all under 5
2. all under 10
3. all under 15
4. all under 18
5. all over 18
6. some under 18 & some over 18
7. no children now
8. not yet foster parents
9. other_____

19. Is at least one parent in the home providing parenting and supervision?

1. Yes 2. No, Parent(s) have work responsibilities outside of the home.

20. Length of involvement as foster family: _____years
21. Number of foster children for which licensed_____
22. Total number of foster children since being a foster parent_____

23. Circle general age groups of foster children you have served:

1. 0 - 24 mos.
2. 1 - 6 years
3. 0 - 12 years
4. 0 - 18 years
5. 0 - 21 years
6. short term/emergency

FOSTER CARE WORKER SECTION

24. What type of agency are you employed or licensed through?

1. County Department of Social Services
2. Private Child Placing Agency (please specify) _____
3. Indian/Tribal
4. Other _____ (please specify)

25. Are you currently employed as a foster care worker? 1. Yes 2. No

26. Length of time in current agency _____years

27. Current title:

1. Caseworker I
2. Caseworker II
3. Caseworker III
4. Supervisor I
5. Supervisor II
6. Foster Case Trainer
7. Other (specify) _____

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28. Length of time in current position _____years
29. Length of time in protective services/foster care unit _____years